



# PATIENT REGISTRATION

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Jr., Sr., etc.) Sex: M or F  
 Street Address: \_\_\_\_\_ Apt./Space: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_

### CONTACT INFORMATION (Check the box next to the best contact number)

Home phone: \_\_\_\_\_  Work Phone: \_\_\_\_\_  Cell Phone: \_\_\_\_\_  
 Email address: \_\_\_\_\_  
 EMERGENCY CONTACT: \_\_\_\_\_ Relation: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

PARENT / RESPONSIBLE PARTY FOR PAYMENT: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: (If different from above) \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

### INSURANCE INFORMATION

Primary Ins: \_\_\_\_\_ Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Secondary Ins: \_\_\_\_\_ Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 On the job injury?  YES  NO  
 Worker's Comp Insurance Co. \_\_\_\_\_ Date of Injury: \_\_\_\_\_ Claim #: \_\_\_\_\_ Adjuster's Name \_\_\_\_\_  
 Auto Accident?  YES  NO \_\_\_\_\_ Date of Injury: \_\_\_\_\_ Claim #: \_\_\_\_\_ Adjuster's Name \_\_\_\_\_  
 Attorney's Name: \_\_\_\_\_ Attorney's Phone: \_\_\_\_\_

### PREVIOUS THERAPY INFORMATION

Have you received any other Therapy Services this calendar year?  YES  NO  
 Have you received, or are you currently receiving Home Health Therapy?  YES  NO  
 If yes, please provide dates: \_\_\_\_\_ and the name of Home Health Agency: \_\_\_\_\_  
 Have you received, or are you currently receiving Chiropractic Treatment?  YES  NO

I hereby authorize payment of medical benefits to \_\_\_\_\_, for services furnished to me. I also hereby consent to have treatment and care as prescribed by my physician and / or recommended by the therapist. I also authorize the therapist to release any information in the course of my examination or treatment. This assignment will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original. I HEREBY ACCEPT FINANCIAL RESPONSIBILITY FOR ALL CHARGES INCURRED WHETHER OR NOT I HAVE INSURANCE COVERAGE. VERIFICATION OF BENEFITS WE RECEIVE FROM YOUR INSURANCE COMPANY IS NOT A GUARANTEE OF PAYMENT.

\_\_\_\_\_  
 Patient or Responsible Party Signature

\_\_\_\_\_  
 Date